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# Congress of the United States
## House of Representatives

July 31, 2002

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FEDERAL COMMUNICATIONS COMMISSION
OFFICE OF THE SECRETARY

Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, D.C. 20554

Re: In the Matter of Rural Health Care Support Mechanism
WC Docket No. 02-60

Dear Secretary Dortch:

The importance to our nation's rural communities of reinvigorating the rural health care universal service support program to improve access to medical care and to educate and prepare rural residents for bioterrorist or other health-related emergencies cannot be overstated. The vision of improved and affordable access to state-of-the-art medical care and health-related education in rural areas that Congress mandated in the Telecommunications Act of 1996 (1996 Act) has been too slow to take hold. We are now in the fifth year of experience with the rural health care support mechanism, and, while some improvements were made initially, I remain unconvinced that the program is meeting the express mandate of Congress. For this reason, I commend the FCC for considering modifications to the rural health care universal service support mechanism to better realize the vision of Congress, and I urge swift implementation of the rule changes.

Rural telemedicine programs provide access to specialty health care services not available locally and play a critical role in informing large areas of the nation about emerging threats and ways to improve preparedness. Often these programs enable rural communities to diagnose, treat, and contain possible outbreaks of disease in a more capable and cost-effective manner, and provide better health care to local residents by facilitating a fast transfer of critical information to far-away experts and specialists. In my Congressional District, for example, several telemedicine clinics are serving residents who otherwise would face the burden and expense of travelling a great distance to tertiary and quaternary medical care facilities. All too often, rural residents cannot afford such travel, and ultimately suffer from lack of access to timely health care services.

Telecommunications and information costs are a major barrier to affordable telemedicine in rural areas. The rural health care universal service support mechanism was established to assure that rural residents can access the same type of state-of-the-art

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health care and instruction that is enjoyed by residents of densely populated urban areas. With our nation's renewed attention and resources committed to preparing for bioterrorist and other national emergencies, telemedicine is a tool for cost-effective, high quality and ubiquitous health care, and must be vigorously supported.

The FCC should take immediate steps to make the program more useful for rural health care providers by recognizing the limited bandwidth options that may be available to those providers as compared with their urban counterparts. The Commission also should eliminate other restrictive rules which are inconsistent with the goals of the statute and streamline the application process in the ways discussed below. By making these simple, common-sense rule changes, the Commission would not greatly expand the scope of the discount program; rather, it would conform the program to the original intent and explicit expectation of Congress.

## Failure to Meet Congressional Expectations

The rural health care universal service support system is greatly underutilized. Disappointingly few of the 8,297 eligible rural health care providers participate in the program, yet our rural residents continue to have only limited access to the type of telehealth and telemedicine programs envisioned by the policymakers who established the program. The overly-narrow rules and cumbersome application process that characterize the program do little to incentivize health care providers to expand their rural coverage or to partner with other rural entities to offer more widespread access to affordable telemedicine and telehealth. In turn, there is no pressure from these entities on telecommunications companies to invest in new technologies that may offer more affordable service to rural areas. This predicament is grossly at odds with the express mandate of Congress to make affordable telecommunications and information services available to health care providers serving rural areas.

I am troubled that the program, in its first three years of operation, dispersed only a meager $13 million, out of a possible $1.2 billion, in discounts. While some commenting telephone carriers quibble with the $400 million annual cap authorized by Congress, calling it overly generous and advising the FCC not to treat the full cap as money available to spend freely, the disappointing utilization of the program speaks volumes about whether the program is meeting congressional expectations. The FCC must closely examine why only a fraction of the 2,500 applicants who received initial applications completed the application process and established their eligibility for the discounts. The FCC also should examine the applicant repeat rate – it is my understanding that after the first year more than 30% of the participating health care providers failed to renew requests for discounts. And in Funding Year 3, the program was utilized by only 703 out of a potential 8,297 eligible providers. This paltry utilization rate, combined with a low applicant repeat rate, signals severe structural flaws with the current implementation of the program.

Pursuant to Section 254(h)(1)(A), Congress directed the FCC to ensure that health care providers serving rural communities pay no more than their urban counterparts for their telecommunications needs. Similarly, Section 254(h)(2)(A) requires the FCC to enhance access to advanced telecommunications and information services for all health care providers. For providers of telehealth and instructional services to patients and health care professionals in rural communities, this element of universal service funding has been viewed as crucial to the sustainability of networks, and, consequently, the ability to provide access to critically needed health services to the underserved rural populations of our nation. It was fully the intent of the Congress that these funds be utilized to encourage and help sustain our rural telehealth programs and initiatives.

As set forth in the Conference Report accompanying the 1996 Act, Section 254(h) "is intended to ensure that health care providers for rural areas, elementary and secondary school classrooms, and libraries have *affordable* access to *modern* telecommunications services that will enable them to provide medical and educational services to all parts of the Nation."[1] The Conference Report further stated, "[t]he ability of K-12 classrooms, libraries and rural health care providers to obtain access to *advanced telecommunications services* is critical to ensuring that these services are available on a *universal basis*."[2] In fact, the Congress clearly expected that such "universal access will assure that no one is barred from benefiting from the power of the Information Age."[3]

Furthermore, as the Commission recognizes, greater utilization of the rural health care support mechanism will benefit the development of a broader and more fully integrated network of health care providers across the nation, which can serve as the front line in a bioterrorist or other health-related disaster.[4] Telehealth programs typically provide continuing medical education programs for remotely located health professionals, which may include informational sessions for patients. In the wake of September 11th, many telemedicine networks have been used to disseminate critical health-related information such as CDC Bioterrorism lectures sponsored by the Secretary of Health and Human Services.

To date, the federal government has funded hundreds of millions of dollars in telehealth-related grant programs, through such agencies as HRSA, the Department of Defense, the Indian Health Service, NTIA, the National Library of Medicine, USDA, and the Appalachian Regional Commission, all with the common goal of enhancing the health of our citizens. In an assessment of past and present grantees of the Office for the Advancement of Telehealth, grantees unanimously identified high telecommunications costs as the primary impediment to the sustainability of their programs when federal funding concludes. Without affordable broadband connectivity, existing programs may falter and fewer new networks will develop and flourish. Few small community hospitals or rural community health centers can afford to pay $860/month for T1 service, the current cost of such connectivity in my rural district.

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1 Conference Report 104-230 at 132; emphasis added.

2 *Id.*; emphasis added.

3 *Id.* at 132-33.

4 *See* 47 U.S.C. sec. 151, NPRM at para. 12.

## Eligible Services

The Commission should establish a mechanism for direct support of Internet access services for rural health care providers. Pursuant to Section 254(h)(2)(A), in conjunction with its authority under Section 154(i), the Commission is directed to support services necessary to access the Internet. The delivery of telehealth services is moving rapidly towards an Internet Protocol platform. Health-care information shared over the Internet is an increasingly vital component for rural health care providers to diagnose, treat and contain possible outbreaks, or provide health-related instruction for such emergencies. Internet access, in conjunction with broadband connectivity, better enables health care providers and the utilizing public to enjoy interactive encounters, distance learning activities, and teleradiology services.

To deny discounts on Internet access, whether provided via dial-up or broadband facilities, is to further increase the isolation of rural areas in contravention of the express goal of Section 254(h)(2)(A). I urge the Commission to recognize support to rural health care providers for Internet access under section 254(h)(2)(A), and to do so according to a percentage discount akin to the schools and libraries support. Nothing in Section 254(h)(2)(A) suggests that the FCC must import the complex rural-urban rate comparison of section 254(h)(1)(A) into a support mechanism for advanced telecommunications and information services. In fact, in directing the FCC to enhance access to advanced telecommunications and information services, section 254(h)(2)(A) uses the term "health care providers" without any restriction to those serving "rural" areas.

## Calculation of Discounted Services: Similar Services

The Commission should adopt a general rule that allows for support of any "functionally similar" service in rural areas to the services available in urban areas. The 1996 Act specifies rates for "similar" services – not the exact "same" service. Health care providers can, and should be encouraged to, fulfill their telecommunications needs using a variety of technologies, including T1s, fractional T1s, DSL, SDSL, ISDN, frame relay, ATM, satellite services, *etc.* From the health care provider's standpoint, each of these technologies offers connectivity at a specified bandwidth rate, and it is the rate that is the most critical differentiator.

The FCC's policy of only comparing technically the same or similar services between rural and urban areas further reinforces the inequities between urban and rural health care providers. Health care providers serving urban areas may have more choices for bandwidth than their rural counterparts, or access to services that are available only at a higher price in rural areas. Rather than a T1 line, for example, urban providers may choose to receive connectivity through a DSL line or a cable modem, which may not be available in the rural community where the need for high quality telemedicine and

telehealth is the greatest. The strictly-technical comparison of services currently conducted fails to account for this reality.

Consistent with the principles of the statute, when rural providers do not have similar connectivity alternatives, the FCC could use as the benchmark the rates for bandwidth provided by any telecommunications technology, including cable modem, satellite, DSL or other emerging technologies, rather than a strict technical comparison. With that change, the purpose of the statute would be served by equalizing bandwidth options, which are transparent to the user of the telehealth facility, between rural and urban health care providers.

The FCC's examination of functionality comparisons must be viewed in conjunction with the need to discount "advanced telecommunications" and Internet access services under Section 254(h)(2)(A) for health care providers. In doing so, the FCC need not employ the rural/urban rate differential as the discount structure, since Section 254(h)(2)(A) does not require such a comparison. Accordingly, the FCC can provide a more simple, and far more equitable, solution by employing a discount percentage akin to the schools and libraries program for the provision of broadband connectivity and Internet access to rural health care providers.

## Calculation of Discounted Services: "Nearest" Urban Area and Maximum Allowable Distance Restriction

Current rules for the rural health care support program take a simple, easy-to-comprehend concept and add a remarkable level of unnecessary and counterproductive confusion. This aggravating level of complexity runs counter to the goals of the statute, diverts valuable administrative resources, and deters health care providers from seeking much-needed discounts.

The clear objective of Section 254(h)(1)(A) is to reduce financially burdensome disparities in the provision of telecommunications services to rural health care providers in order to put the telecommunications costs of rural health care providers on equal footing with the costs in the densely populated urban areas in their state. The 1996 Act says nothing about equalizing these burdens only for the nearest city of 50,000 inhabitants. To better effectuate its congressional mandate, the FCC should modify its rules to allow comparisons based on telecommunications costs in any city in the state. The commenters demonstrate that the increase in demand from eliminating the nearest city requirement will not come anywhere close to the $400 million annual cap authorized by Congress.[5]

Section 254(h)(1)(A) is intended to assure rural residents that when it comes to their health care, they will have the same advantages as urban residents. Densely populated urban areas tend to be the earliest beneficiaries of advances in telecommunications technology. When the nearest city of 50,000 is itself located in a

[5] *See, e.g.*, Comments of the Office of Telemedicine of the University of Virginia at 15.

largely rural area, health care providers in rural areas are not receiving the full benefits of economies of scale and scope that are available in the densely populated urban areas, which exacerbates the disparity between a state's rural and urban health care providers. The 1996 Act simply provides that telecommunications rates for rural health care providers should be "reasonably comparable to rates charged for similar services in urban areas in that State." Removing the "nearest" restriction would allow, for example, a telehealth facility serving Southwest Virginia to receive a benchmark rate from a carrier serving Northern Virginia, which would be fully consistent with the statutory language. The Commission should recognize that the rates and services available in small cities, or cities located in predominantly rural areas, do not fully reflect the economies of scale and scope in more densely populated areas of the state, and therefore remove the "nearest" city restriction. The legislative history supports this removal, seeking to ensure that rural health care providers have access to the type of lower-cost telecommunications alternatives available in the more densely populated urban areas.

In particular, with respect to distance-based charges, the Maximum Allowable Distance (MAD) restriction, which limits rural health care providers to discounts for connection to the nearest city of 50,000 or more, serves as an unnecessary complication to the administration of the program and to the creation of a comprehensive telemedicine network. This MAD restriction is not found in the statute, and runs counter to the statute's purposes. Commenters point out that the requirement artificially constrains the practice of referring patients, as patient referrals often bypass the nearest city to connect patients with more specialized expertise and care located in a different city in the state. FCC policy should encourage rural health care providers to connect with any health care facility with the appropriate expertise to ensure an adequate level of preparedness regardless of where in the state that facility is located. In order to promote the development of a rural health care network that is adequately armed for the Information Age, the FCC should remove the MAD restriction without regard to the potential increase in demand, and reevaluate the effect on demand after a period of time has elapsed without a MAD restriction.

## Eligible Health Care Providers

Any not-for-profit health care facility that provides direct medical services to rural areas should be considered eligible for discounted telecommunications services. As commenters more-than-adequately demonstrate, facilities such as nursing homes, dental clinics, school health clinics, and emergency medical service facilities, provide the type of direct patient care that should be included within the reach of the rural health care universal service support program. In addition, where a for-profit hospital is the sole provider of healthcare services in a rural area,[6] the FCC should consider allowing that hospital to benefit from the telecommunications discounts in order to ensure full support

[6] *See* Comments of the Office of Telemedicine of the University of Virginia Health System at 8 (describing how the acquisition of two bankrupt not-for-profit hospitals in Southwest Virginia by a national for-profit corporation resulted in the loss of the telecommunications discount to the only local provider of inpatient and emergency care).

for a comprehensive public health networked infrastructure in our nation's rural areas. The FCC could do this by examining whether certain for-profit hospitals are public in nature by virtue of the beneficiaries they serve, including their percentage of Medicaid and Medicare recipients.[7]

The Commission should also rethink its conclusion that a rural nursing home is ineligible for the discounts even if it is part of an eligible rural health clinic. It is my understanding that some rural health care clinics and emergency service facilities have been denied discounted telecommunications services because they also function as nursing homes, hospices, or other long-term care facilities. Multi-purpose providers which serve as a recognized rural health care provider but also in other capacities which complement the health care services should not be punished for offering *more* services to rural areas. Consistent with its statutory mandate, the FCC should encourage – rather than retard – these arrangements, which provide a crucial link in our nation's health care network infrastructure and overall preparedness.

The program also should encourage health care providers to partner with clinics at schools and libraries in rural locations, rather than subjecting each partner to a potential lack of funding. I have been informed that some health care providers and their associated school clinics have been denied discounts from the rural health care and the schools and libraries programs because each program considers the entity better suited for the other program. This result is untenable under the statute's clear intent to promote affordable telecommunications for schools, libraries, and health care providers. Although it is intended that a health care provider which shares supportable services with a school or library be able to allocate costs among the eligible entities, it is my understanding that in practice this is difficult to do.

There is nothing in the statute that requires that a telecommunications network used for purposes in addition to the provision of rural health care or instruction automatically falls outside of any discounts. The Commission should rethink the effect on the overall development of a broad, fully integrated public health networked infrastructure from its requirement that a health care provider certify that the telecommunications service will be used solely for purposes necessary for the provision of health care or instruction. To avoid potential abuse of any broader applicability, the FCC could require health care providers to keep specified documentation of the utilization of the connectivity for clinical encounters, medical data transmission, health related education, or other acceptable purposes, which could be subject to random auditing or other safeguards.

## Other Changes: Highest Tariffed Rate

The Commission should also reexamine whether permitting carriers to charge the highest tariffed rate discourages telecommunications carriers from making services more

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[7] *See* Comments of the Office of Telemedicine of the University of Virginia Health System at 10-11 (citing precedent for broad interpretation of "public").

affordable to rural areas. Requiring that a telecommunications carrier must charge their "highest tariffed rate" for services underwritten by USAC does little to encourage carriers to lower costs, lower rates, or add new infrastructure or services which may be more affordable. Carriers may in fact be keeping those rates artificially high in order to recoup more from the universal service fund. The Commission should examine ways in which it could encourage carriers to lower costs and still receive full support, such as, at minimum, posting the rates on a web site to increase the transparency.

## Streamlined Application Process

Commenters also suggest a number of common-sense ways to streamline the application process. The FCC should expeditiously implement these changes in order to reduce the administrative burdens that deter many eligible rural health care providers from utilizing the program. In particular, the FCC should ensure that eligible telecommunications carriers are encouraged to supply the information necessary for rural health care providers to complete the application process. It is my understanding that rural health care providers have faced difficulty in obtaining urban rate quotes and other information from eligible telecommunications carriers that do not serve the location of the rural health care provider.

## Conclusion

It is my fervent hope that the FCC will expeditiously modify the rules of the Rural Health Care Program in the ways which I have outlined and in other ways which will enhance the viability and sustainability of the nation's existing telemedicine and telehealth programs and encourage the deployment of greater numbers of such initiatives. Taking such a step is likely to stimulate broadband deployment in rural communities and further solidify our nation's critical public health infrastructure to prevent and prepare all of our nation's citizens for the threat of terrorist and bioterrorist activity.

Thanking you for your time and attention to this matter, I remain

Sincerely,

Rick Boucher
Member of Congress

cc: Chairman Michael K. Powell
Commissioner Kathleen Q. Abernathy
Commissioner Michael J. Copps
Commissioner Kevin J. Martin
Dorothy Attwood, Chief, Wireline Competition Bureau